Cromwell

THE JOURNAL OF SCHOOL HEALTH

Vol. XIX No. 7

SEPTEMBER
1949

PUBLISHED BY
THE AMERICAN SCHOOL HEALTH ASSOCIATION

AMERICAN SCHOOL HEALTH ASSOCIATION

Organized 1927

Devoted to the interests and advancement of those engaged in school health activities and the service rendered by them

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Vol. XIX SEPTEMBER, 1949 No. 7

CONTENTS

Reasons for Lack of Treatment of Physical Defects of High School Pupils 173
Marie Swanson, R.N.

Educational Implications of Clinical and Research Findings in Nutrition 180
Elizabeth Lockwood, Dr.P.H.

There Is No Average Boy 186
J. Roswell Gallagher, M.D.

Program of Annual Meeting 195

Editorials 200

Abstracts and Notes 179, 185, 194, 201

Reviews 204

Meetings 206

THE JOURNAL OF SCHOOL HEALTH

THE AMERICAN SCHOOL HEALTH ASSOCIATION

3335 Main Street, Buffalo 14, N. Y.

Published monthly, except July and August, at Buffalo, N. Y.

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SUBSCRIPTION RATES TO THE JOURNAL

Membership dues, $3.00 including Journal: Subscription $3.00

Single copies 35c, send payment with order

Address all communications to

THE EDITOR, The Journal of School Health

3335 Main Street, Buffalo 14, N. Y.

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The American School Health Association

Entered as second-class matter at the Post Office at Buffalo, N. Y.
October 5, 1937

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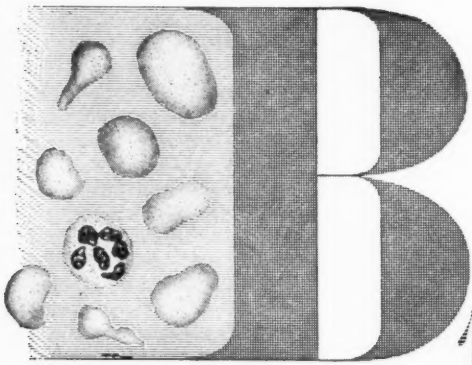

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THE JOURNAL OF SCHOOL HEALTH

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Vol. XIX SEPTEMBER, 1949 No. 7

REASONS FOR LACK OF TREATMENT OF PHYSICAL DEFECTS OF HIGH SCHOOL PUPILS*

MARIE SWANSON, R.N.

School Nursing Consultant, National Organization for Public Health Nursing; Formerly Supervisor of School Nursing, New York State Department of Education

This paper is based on a study of "Reasons for Lack of Treatment of Defects of High School Pupils" made in 1942 by 470 high schools of New York State. At that time the results were summarized and a report prepared by the Health Service Bureau and the Research Division of the New York State Education Department. The Report was approved by the Commissioner and ordered printed but this is its first presentation.

For many years measures have been in force in various states which insure treatment of defects before pupils are given working papers for part time or vacation employment or before they are allowed to leave school to go to work. While individual schools have successfully required treatment as a prerequisite for graduation just as some have for pupils who are to represent the school in such activities as athletics, music, debating, drama, etc., I know of no state with a law requiring treatment before pupils are graduated or leave school because of age.

Pupils Studied

In April, 1942, blanks and directions for a study of 20 pupils with untreated defects were sent to the principals of the high schools in New York State whose health service is under the supervision of the Health Service Bureau of the New York State Education Department. This includes the approved public high schools of the State with the exception of those in New York City, Rochester and Buffalo.

61% of the principals (470) to whom the blanks were sent (principals of all approved high schools of New York State with the exception of those in New York City, Rochester and Buffalo) returned them. 70% of city high schools participated, 75% of

* Extracts from a paper given November 8, 1948 at Annual Meeting of American School Health Association, Boston, Massachusetts.

those in villages, 51% in union free schools and 66% in central rural schools. Of the pupils whose records were reviewed, about a quarter each were in the high schools of cities, villages, union free schools and central rural schools.

The returned acceptable blanks (3.1% of the cases reported had to be discarded because of errors, omissions or misinterpretation) showed a review of the health records of 66,871 pupils, of whom 8,301 (12.4%) were shown to have 9,636 defects still untreated (an average of 1.1 defects apiece). The number of defects already treated in the group was requested but incomplete data were returned on this, due to the fact that while a current record of untreated defects is kept in many schools so they may be worked on, a summary of treated defects is not made until the close of the school year. This study was made in April, (1942)

On receipt of the blanks, individual cards were punched for each pupil with untreated defects, showing the number, type and degree of his defects, his age and grade, and the number of years the defect had been reported to his parents for treatment. The size of the school and community were indicated, together with efforts the school might have made to secure treatment such as conferences between a member of the school staff and the pupils regarding the need for treatment, contacts by a member of the school staff with the parent to discuss the problem, conferences with cooperating agencies regarding possible assistance and whether the school has in its files a notice of the defect signed by the parent, proving the parent does know of the defect. Finally the reason for lack of treatment was given as accurately as the school could determine it. The member of the school staff who made the study and the type of nursing service in the school were noted.

Types of defects

Of the untreated defects, about one-half were of teeth, one-fourth of tonsils, and one-eighth of eyes. The remaining one-eighth was made up of twelve different defects: orthopedic, ears and wax, nutrition, heart, thyroid, skin, hernia, nose, glands, reproductive organs, speech, and nervous system.

The untreated defects of the most long-standing duration are those of nutrition, especially of obesity.

Next in order were those requiring (or which seem to the parent to require) surgical treatment—orthopedic defects, tonsils and hernia.

Speech and hearing are also persistent.

Those defects which had the largest proportion, reported that year for the first time were ears (mostly for removal of wax) heart, and eyes.

Reasons for lack of treatment

The reasons for lack of treatment were coded under 28 headings, but most of the reasons grouped under three main headings. First were reasons having to do with the parents' attitude toward the child, the defect and the need for treatment, 45.1%. Second, reasons concerned with lack of money, 31.7%, and third, the pupils' objection to treatment, 14.1%.

In the remaining 9.1% of the cases additional reasons occurred in the following order of frequency: Difference of professional opinion, objection to surgery, guardianship ineffective to direct pupil, objection to treatment on religious grounds, unsatisfactory previous treatment of this pupil or of others in the family or community. 1.75 per cent of the reasons were not classified.

REASONS FOR LACK OF TREATMENT*

Reasons	*Percent of total untreated defects*
Total reasons	**100.0**
A. Parents' Attitude Toward Child, the Defect or Need for Treatment	45.1
1. Parent appreciates need of treatment, expects to secure it, but delays (18.6)	
a. Delays for reasons the schools consider valid, plans made for treament at a definite later date and schools have basis for expecting plans will be followed (6.9)	
b. Delay justified by serious family problems (1.1)	
c. Delay because professional service is difficult to obtain (0.9)	
d. Delay because much dental work must be done; complete dentures (0.3)	
e. Delay, no reason given (9.4)	
2. Parent considers treatment not needed (7.0)	
3. Parent seemingly lacking in parental responsibility, indifferent to pupil's welfare (19.5)	
B. Reasons for Lack of Treatment Having To Do with Lack of Money	31.7
1. Delays and inadequacies in availability of money from official welfare sources (3.0)	
2. Refusal of money by official welfare sources for this purpose (1.7)	
3. Welfare sources were refused by family (1.0)	

* Copies of the complete set of 12 tables upon which the paper is based are available from the National Organization for Public Health Nursing, 1790 Broadway, New York 9, N. Y. There is a 25c charge to cover cost of mimeographing and mailing.

4.	Financial reasons not associated with official welfare assistance	(26.0)	
	a. "Unofficial help" not available, and school believes defects would have been treated if it were	(16.0)	
	b. "Unofficial help" was available, but was refused by family	(3.6)	
	c. Parent expects to have money later to pay for treatment	(3.0)	
	d. Parent is paying for pupils' siblings health needs and will secure this treatment soon	(1.9)	
	e. Pupil expects to earn money soon for treatment (This was accepted only for the first year of defect reporting, and when pupil had definite plan)	(1.5)	
C.	Pupils' fear or dislike or indifference to treatment		14.1
D.	Differences of professional opinion		2.3
E.	Objection to surgery		1.4
F.	Guardianship ineffective to direct pupil		0.8
G.	Objection on religious grounds		0.7
H.	Unsatisfactory previous treatment of pupil, member of family, or someone known to them		0.4
I.	Unclassified or undetermined		3.5

Reasons classified according to recorder

The importance of determining the real reason for lack of treatment of a defect as a preliminary to setting in motion forces to secure the treatment is too abvious to need discussion.

In some instances the reason for lack of treatment of a school child's defect is easily established. He needs a tonsillectomy. The family is on relief. They have taken him to a clinic and signed the necessary permission. Because of the long waiting list he has been given an appointment seven months away. Clearly "inadequate community facilities" is the proper classification.

A girl needs her glasses changed. It has been three months since her mother returned the written notice saying it would be attended to as soon as possible. The family lives well and shows many indications of financial prosperity. The mother is not employed but leads a busy social life. With tears in her eyes, the child says to her teacher, "Yes, I know I would do better work if I had my new glasses. These make my head ache and I cannot read very long." "Why don't you get them?" "Well, I am going to, but it means a day in the city and it is hard to get an appointment We have had one twice, but each time something more important came up that Mother had to do here. Anyway she says I inherited these bad eyes from my father so he ought to take me in but he says he cannot have me manging around the office all day. But, I guess I'll get them pretty soon." One suspects that verification will result in chalking that one up as "parental indifference."

Fourteen year old Harry has teeth that need attention. His mother tells the teacher "Harry just did not keep his appointment with the dentist last week. Can you do anything to help us make him keep the next one?" "That can well be accepted as child's objection."

But, there is another situation. In this family the six year old needs to be examined for glasses and the 10 and 16 year old daughters need their glasses changed. There is a new baby. The budget is tight. The father hesitates between delay for another quarter of the increase he feels he ought to make in the insurance he is carrying to protect his family or delaying the glasses. Certainly this reason cannot be classified as indifference to his children's needs.

Peter should have an operation on his nose. It does not have to be done today or tomorrow but should be done soon. In June the family planned with the nurse that they would have it done during the summer. In July, Peter had a vacation job. Now, in August, he thinks, "I bet I can't go out for football if I have that operation. Still I would like to get it over." His mother thinks "Oh, I am so afraid of operations," (when she was six the little brother of her girl friend "died on the operating table") "but I know the doctor is right when he says it should be done." His father thinks: "Well, he seems to be alright and this is the year we could take that camping trip we planned all through the war. A good vacation is a health factor and the operation would mean no vacation for the five of us,—which is really more important? I don't know what to do." When procrastination continues in this way, should we say it is the boy's objection, the father's finances or the mother's fear that causes the delay.

Establishment of procedures to deal with reasons for lack of treatment

In 31.7% of the cases, lack of treatment had to do with lack of money so the contacts of the school with community agencies are of significance.

Since the per cent of cases in which "welfare" was concerned was 5.7 of the total number and since 5.6% of the total cases were discussed with "official agencies" it would appear the schools are quick to "confer" with agencies when there are agencies with whom to confer, as is the case with official welfare agencies.

But the big difficulty comes in reference to the 16% of the cases stated as not receiving treatment because of lack of "unof-

ficial money" with which to assist the families. Though there might be a question as to whether it is the school's responsibility to organize such agencies when they do not exist in a community (as many schools have done), there can be no question of the school's responsibility for putting before the community the needs of the pupils which are not being taken care of.

While it is generally accepted educational policy that the school should not "furnish relief," in all cases where money is involved, the school has certain possible contributions to make.

It can plan with welfare officials for pupils who need treatment from families which are indigent or medically indigent.

It can assist pupils in planning to earn money (these are high school pupils.) Many schools have administered a N.Y.A. program to this end. Many others cooperate with part-time employment plans.

The home economics teacher can assist pupils and families in budgeting.

The school can plan with community agencies for the development of funds for loan, reduced pay and part pay plans.

The school should give sufficient health knowledge to its pupils so they should know the desirability of treatment, but it needs to secure the cooperation of church and community youth organizations for help in changing these attitudes toward personal health as a community as well as a personal responsibility.

The per cent of pupils in the total group studied who objected was quite constant for the variations in size of the community in which the school was located.

The proportion of untreated defects of tonsils and ears was much larger in rural than in urban, correlating with the absence of specialized service in the rural areas.

With seven of the reasons there were variations according to the type of defect.

There is the greatest contrast in "professional difference of opinion" which is very low in reference to teeth, quite low in reference to eyes, but very high in reference to tonsils. Incidentally other high rates of differences in professional opinion are on hernia (8.26%)* on hearts (7.52%)* and on nutrition (4.92%*.

Parents refuse to accept tonsils as a problem needing attention more than six times as often as they do defects of teeth and eyes.

The pupils' own objection is stronger when treatment of eyes is concerned than in reference to any other defect.

* Of the total differences of opinion.

These data would indicate the need to seek the cooperation of the organized medical group of the community in determining standards acceptable to the group to reduce as much as possible, the difficulties due to differences in professional opinion.

The school needs to seek the cooperation of adult education groups, and church and community organizations to instruct the parents in health standards and to change their attitudes toward health problems. Individual and group conferences, publicity, educational materials and individual conferences are all helpful.

In cases having to do with parents' attitude toward the child, the assistance of social agencies, child guidance clinics and children's court are available.

When the difficulty resolves itself around the parents' attitude toward the defect, conferences with the school physician and the family physician are most effective.

The value of team work appears again and again. The best physician can't do the job alone. The most energetic and effective nurse reaches the point where she must have reinforcements.

Even though every member of the school staff participates, even this group cannot do it alone. The team might include parent and community if we hope to secure for every child what he needs.

* * * * *

Boxing and Intracranial Injuries,—Romino says that with the present increase in ring accidents closer study of participants must be made in order to determine the fitness factor. He suggests that boxers should be licensed. Before a license is granted, he should undergo a physical examination. This license should be renewed each year. A boxer should have a medical record of each fight and present this to the commissioner at the time of renewal of his license. The license should be shown to the doctor and a physical examination must be made before each fight. A fighter who has been knocked out should not be permitted to fight for three months. No fighter whose blood pressure is more than twenty points above normal for his age group should be permitted to fight because, in addition to the danger of serious intracranial injuries, it is likely that fighters whose blood pressures are elevated receive, in the course of a bout, numerous petechial hemorrhages which sooner or later result in a "punch drunk has-been". Each fighter should present the doctor with a signed affidavit from his manager, stating that he has undergone sufficient training. The managers should see their boxers are evenly matched. Journal, American Medical Association, June 18, 1949, p. 652.

EDUCATIONAL IMPLICATIONS OF CLINICAL AND RESEARCH FINDINGS IN NUTRITION*

ELIZABETH LOCKWOOD, Dr., P.H.
School of Public Health, Harvard University

Many of the research studies in nutrition, which have been conducted within the past few years, show very important and challenging educational implications. I would like to recall certain facts as suggested by these pieces of research.

1. that few children in this country are receiving adequate daily diets in essential nutrients according to NRC recommendations;

2. that when the situation is controlled and healthful daily living is provided, as in a few of the research studies, the health and nutritional status of children involved is improved;

3. that malnourished children are open to infection and are often school problems because of physical, emotional and mental maladjustments;

4. that where certain supplementary dosages of nutrients are given, the health and nutritional status of the children can be improved;

5. that dietary status is not primarily dependent upon economic status:

6. that it is difficult for families to maintain adequate diets in face of changing incomes, rising good costs, and changeable food supplies.

The majority of the research studies have been institutionally or privately conducted and their methods and techniques are not possible on a broad scale throughout the country. Certainly nutrient supplementation is not feasible. Wherever possible, however, the findings of such research can be made available to the community so that they can serve as a foundation for a follow-up program of actions. If this is not done, the real benefit of the research to the locality is lost.

It is quite possible to use the finding of a research study as a stimulus for general nutrition education on a large scale, to bring about an improvement of dietary habits. The results over a long term program will be as benefiting to an area, and undoubtedly will be more permanent, as where a research program has attempted to use itself as the instigating instrument. With either

*Read before the joint session of the American School Health Association and the Nutrition Section of the American Public Health Association, November 10, 1948, at Boston, Mass.

method, it is not an easy task, for the complacency of the American people is renowned.

The most important educational implication from research in nutrition conducted through the media of schools and communities is this apparent vast need for nutrition education for the public today. There are various suggestions from the education standpoint as to how such a program can follow from findings furnished by a research study. These fall into two categories: 1) aid to the community, and 2) aid to the school.

I. Community:

Many, in fact most, communities have the same dietary lacks as found by the various research studies conducted in Michigan, Maryland, Georgia, Mississippi, Louisiana, Massachusetts, Vermont, and North Carolina. All these localities have been aided by the research studies taking place in their areas, but the majority of them could never have afforded the research for themselves. Outside agencies have had to be responsible for such aid. This means that in the majority of places in the United States today there is ignorance of the nutritional status of the people. Unbalanced diets of families and communities are common. They are often more harmful than the underfeeding of other areas.

It is definitely true that the nutritional status of a family is not dependent alone upon its economic status. The inadequate breakfasts, luncheons, and dinners or suppers testify to this. Some of the poorest meals from the nutritional standpoint are found in homes well able financially to "set a good table". It is also true that in general the smaller the family size, the better the diets. But it must be remembered that the food dollar spent influences the meals served. In the Maryland study (1), it was found that where the families' food quota was $4-6 weekly per person, there were twice as many families with adequate diets as where only $2-4 were spent weekly per person. There is a definite limit that one can go in providing nutritious foods according to the food budget. Thus, one of the strong educational needs of most communities today is information regarding food costs, food equivalents in relation to nutrients, and information concerning a needed daily basic diet for persons at the different age levels.

In the Vermont study in 1946-47 (2), there was a definite drop

1. Experience in Appraising Nutritional Status in the United States Public Health Service, American Journal of Public Health, Vol. 38, No. 3, March, 1948.
2. A Nutrition Survey of Some Vermont Children, Nutrition Reviews, Vol. IV, No. 6, June, 1946.

in the findings in relation to the intake of nutrients. Similar results were noticed in our Newton study for the same period (3). Certain foods were not available or were considered too costly. People simply omitted them and did not know what to put in their place as dietary equivalents. *People of all ages need consumer education,* and need it more than ever before.

Consequently, one of the important implications from research studies today is the vital need for community nutrition education. A second educational implication is in regard to the school and its setting.

II. The School:

What better place is there to start the education of the general public in relation to bettering dietary habits than in the schools of the country? A planned school program from kindergarten through the high school should eventually bring forth a better trained and more informed general public. Certain surveys have shown that where mothers of families have completed the eighth grade in school and have had the benefit of one year of home economics training, they do a much better job of feeding their families. If one year of contact with food preparation and food acquaintance can improve standards, let us give nutrition education a deserved place throughout the entire school years.

A better school health environment for children can be brought about in various ways:

a. *by making possible a better dietary intake.* This may be accomplished through the school lunch program. In other words, the school can take over the task of supplying 1/3 of the daily nutrient needs.

It has been pointed out by several of the research studies that citrus fruit intake was low in the winter and spring months (1, 2, 3). Infections and colds quickly use up the slight storage of ascorbic acid. One way of remedying this is by increased amounts of foods high in vitamin C content in the school lunch.

Also, the milk furnished by the school lunch often provides the difference in whether or not a child is low in colories, protein, calcium and riboflavin. In Cumberland, Maryland, only 50% of children were adequate in daily nutrients where they carried their lunch and went home to lunch; some 70% were adequate where they partook of the school lunch (1).

Another way of contribtuting to a better day's diet is through

3. Research in the Nutritional Education in the Public Schools, Science Education, Vol. 32, No. 3, April, 1948.

camp experiences (4). This type of experience can do wonders in raising the health status of children. Schools in California and Michigan are making the school camp a regular year-round part of their curriculum. It is to be hoped that records will be kept to give the evidence from health and nutritional standpoints.

b. *by having a nutrition education program throughout the school system,* **Based On the Needs** *of the communities and the age groups.*

The earlier in the grades it is started, the better, since food habits are fixed even by the time that children enter school.

Good teachers have always been interested in the health status of their students. But health is sometimes lost sight of in the complications of being "educated." Perhaps more "educating" would be accomplished if the schools concentrated on health first, thereby facilitating learning; because *improved health and nutrition often results in improved learning.*

Another benefit of school nutrition education is the factor that much of the nutrition information given in school goes home to the parents. Often new ideas are more readily accepted from their children than from outside agencies.

It is in this area that community agencies can assist by offering consultant service to the schools and by suggestions and helps to the teachers. The result of such cooperation is in improved community-school program.

c. *by improved health services.*

Certainly the schools or health departments can take leadership in providing physical examinations which will aid in locating the many children needing special help. It is interesting that several of the recent research studies report that more adequate plotting of children's height and weight figures with the proper interpretation, could locate many of the cases of malnutrition. To know better detail about the health status of children not only requires better health records within the school, but *better use of the records* themselves.

The schools need to pay more attention to the past histories of infection in children. More rest, lessened activity, adapted programs are necessary for a time for these children returning to school after a serious infection. Certainly it has been made evident that infection and malnutrition have inter-relations which the school should consider.

4. Nutritional Conditioning in a Health Camp, Journal of American Dietetic Association, Vol. 24, No. 3, March, 1948.

We need better methods and determinations for obtaining dietary knowledge about children. Clinical cases are evident, but the "border-line" cases — and there are many such — have their school life affected as a result of non-detection. Application and adjustment to school, to study, and to classmates are made more difficult. Teachers are all acquainted with the "ten o'clock and three o'clock drag."

The school can give better health to a child even if it does not succeed in giving better learning. Our learning capacities are limited, but our health capacities can serve to increase our potential mental capacities.

d. *by improved teacher-training.*

Healthy teachers are better teachers, and teachers that follow health practices serve as much better examples to children, to aid them in turn in establishing better health habits. Therefore, another implication hidden in research studies of nutrition is the vital need in this country for improved teacher-training in health and nutrition. Few teachers, other than science and home economic majors, have had any training that related to nutrition. Limited knowledge usually leads to *no* nutrition education being included by the teacher, or to false information being given or condoned. Also, teachers lacking nutrition information often inadvertantly permit children to develop erroneous ideas concerning foods that are damaging.

Here again, in this area of teacher assistance, proper agencies should feel a responsibility for supplying aid. The community can do much to stimulate better teacher-training facilities.

Summary:

Educational implications of research studies in nutrition:

1. Nutrition education is vitally needed in the communities and schools today—everywhere in the country.
2. Communities can be aided by programs giving them information in relation to food purchases, food costs, food equivalents.
3. School can be aided by:
   Improved dietary intake for children through school lunch program.
   Better cooperation and coordination between the classroom and the lunchroom so that dietary practices and improved food habits can be encouraged and practiced.
   Encouraging the nutrition education of school programs to be carried into the home.

Improved health services to provide a more adequate coverage of health and nutrition problems.

Improved preservice and inservice training of teachers in the areas of health and nutrition.

* * * * *

Resolution of the New Jersey State School Nurses Association regarding the continuance of a National School Nursing Section:

WHEREAS, The work of the nurse in the school is a specialized service, contributing to the educational experience of the child,

WHEREAS, It has come to be recognized as an essential factor in this experience,

WHEREAS, Those who contribute to the child's education in health are necessarily an integral part of the life of the school and cannot be separated from it,

WHEREAS, The preparation of and the training of the nurse in the school cannot be limited to the basic arts of nursing alone, but needs also to include an understanding of educational aims and practices, as well as the principles and philosophy of education,

WHEREAS, The role of the nurse in the school is constantly broadening in scope and becoming more closely aligned with all educational procedures in the school; be it therefore

RESOLVED, That the New Jersey State School Nurses Association go on record for the continuance of a School Nursing Section and request that a School Nursing Section be provided for in any new structure of the National Nursing organization; be it further

RESOLVED, That this resolution be spread upon the minutes and a copy be sent to Miss Hortense Hilbert, Chairman of the National Structure Committee, and to Miss Geraldine Hiller, Chairman of the School Nursing Section, N.O.P.N.N. Passed at the Annual Meeting, May 21, 1949.

* * * * *

Colds in Children Attending Nursery School and in Those Who Do Not,—Subjects of this study by Diehl were 51 children between the ages of 23 months and 56 months. All children were above average in health status. Twenty-five were attending nursery school and 26 were not. The nursery school endeavored to keep sources of infection at a minimum. The number and severity of colds were checked from January 28 to April 8, 1946. There was no statistically reliable difference in the number and severity of colds suffered by children who attended nursery school and those who did not. Journal, American Medical Association, July 9, 1949, p. 919.

THERE IS NO AVERAGE BOY

by J. ROSWELL GALLAGHER, M.D.

(*Reprinted by permission from the Atlantic Monthly, March* 1949)

1

Sam had only just passed his fourteenth birthday but he weighed 150 pounds, was 5 feet 10 inches tall, and might well have shaved every day. His ninth-grade teachers complained that he seemed listless and uninterested and did not show the maturity which they felt a boy as big and as apparently grown-up should have. "You'd think he'd be a leader, but he has no sense of responsibility and he's always doing childish, silly things."

Sam's father was exasperated and his mother confused. "Do you think he's grown too fast—is he average? He seems to be tired all the time; he'll sleep for fourteen hours at a stretch. He won't listen to us and he won't tell us anything—he's polite about it, he just won't talk. We can't let him go to parties fit for seventeen-year-olds and he won't go to parties his classmates give. You ought to see the walls of his room — just covered with Petty pictures — really, Doctor, for a boy of his age! It seems as though he resents every suggestion we make. I wish he either weren't so big or had more sense. Do you think he's all right physically—is he normal?"

Billy lived down the street from Sam. He had been brought up in a similar fashion — their parents had about the same interests, they had attended the same grammar school, had been fed about the same kind of food, belonged to the same church and the same Scout troop. But at sixteen Billy weighed only 115 pounds, was only 5 feet 4 inches tall, and although a little fuzz had recently begun to appear, had no real excuse for shaving. Until his third year in high school, he had been a model boy. His marks had been very good, his behavior faultless. And then in his third year his marks fell off, he seemed preoccupied, inattentive, less willing to participate. He quit the swimming squad — though swimming was a sport which he had always liked and in which he had excelled. At home he became very uncommunicative, was less willing to enter into family gatherings and to meet the family's friends. Parties he dodged.

Billy's mother didn't get much help from his teachers: "He's such a nice boy; there can't be much of anything wrong with him; maybe he needs a tonic." That thought at least had the virtue of getting him to the doctor; and after the inevitable "Do you think

he's overdoing? Could it be his glands — you know I take thyroid? Do you think he gets enough sleep?" the doctor got mamma out, asked Billy to strip, and then settled back to wait until Billy's tears subsided. Billy was normal enough but his growth and development had proceeded at a less rapid rate than usual — a reasonable source of unhappiness and anxiety for a boy.

Sam and Billy aren't average, but they *are* normal. They are relatively common examples of the fact that adolescents vary tremendously in the rate and manner of their growth and development. Some at fourteen look like, and occasionally behave like adults (usually in unacceptable ways). Others at sixteen have the scholastic capacity of their age group, the gonadal development of twelve-year-olds, and an accompanying fear that they are doomed to be abnormal. No one ever did adolescents a greater disservice than the person who initiated the idea that there is an average weight, or height, or grade level in school for any age; or that there is an average age at which boys should take responsibility, drive cars, stay out late, or shave.

The average weight of one group of schoolboys was found to be 127 pounds, but the range in weight of these boys from 80 to 199 pounds is the important fact. There were many who did not even approximate the average weight, yet there were none who were "abnormal." Height tables, weight tables, and growth graphs all have their place and uses, but to evaluate a youngster's growth or health on the basis of these devices, to regard a number on a chart or a dot on a graph as a diagnosis instead of a fact, is to develop anxiety both in boys already fearful lest they be "different" and in mothers who are always comparing their Tom with Cousin Kate's invariably perfect son.

A boy can be well and happy and turn out to be a very fine adult even though he weighs less than the average, has "grown six inches in the last year," or doesn't seem to be "in the groove" on the chart his teacher is keeping. This optimism isn't born of indifference; it is based on the fact that real abnormalities (that is, those which are not due to hereditary or dietary factors) of growth are very uncommon.

It is sensible to be interested in whether a boy *is* growing and gaining and maturing; but neither the rate of his growing nor whether he is "average" at that moment is of any significance: the most and best you can do about these matters is to give him food and affection. Don't worry or cause him to worry. If he is thin, feed him; if he is fat, hope that he will learn that he needs

less food; if he seems too mature before thirteen or not to be maturing by sixteen, send him to your doctor.

Growth or malnutrition or obesity is not important, but too much interest and faith in tables and graphs breeds oversolicitude and anxiety. It is better to upset the scales than to upset the home. At long last we seem to be learning that there is neither an ideal nor an average time for the baby to start eating his spinach or stop wetting his pants, that too much effort at routine and regimentation does more harm than good. Recently that wise pediatrician, Dr. Edith Jackson, by allowing mother and baby to "room-in" together in the hospital, recognized that affection is at least as important as immunizations, that man's emotions are as important as his body.

In adolescence as in infancy, it is family relationships which are the significant factor: these boys want to feel that security, affection, confidence in them, are there. Their apparent indifference and their awkward steps toward independence are deceptive indicators of their inner needs and feelings. There is no quicker way to rob them of security than through oversolicitude, nagging, constant critical appraisal, and too frequent comparison either with the chart or a neighbor's son.

Billy and Sam baffled their parents and teachers not because they were abnormal but because their parents and teachers wanted them to be *average* (which is too often confused with *normal*) and were judging them in a manner they believed suitable and convenient in the management of "average boys." But Sam's height and weight and whiskers were three years ahead of his age, and unfortunately the hormones which produced this early growth had neither eliminated his childish love of horseplay nor instilled powers of leadership as awe-inspiring as his beard. Nor had Billy's hormones, whose inactivity kept him at fourteen although he had passed his sixteenth birthday, allowed an orderly, average development of his body, personality, and interests.

Lawrence Frank has aptly compared the rate at which different children approach adulthood to various types of transportation all headed for the same destination: "some by airplane, some by Twentieth Century Limited, others by bus, some by water, some by hitch-hiking, and others trudging along on foot." They will *all* get there—that is the important fact. Their time of arrival, their condition on arrival, whether they go speedily or slowly — these are simply expressions of their environment and of their inherent differences. It is worth remembering, too, that a boy may

change from one type of vehicle to another when one least suspects it: growth may lie dormant or take a tremendous spurt. There is a wide range within which physical and intellectual and personality attributes are normal, and each individual will proceed according to his own rate and within a pattern determined by his own constitution and heredity.

2

The desire to know what the average is, to want your boy to be average (except, of course, in those fields where to excel is "good"), is understandable. It makes for fewer problems, less confusion in the home and in the classroom; "a good, average boy" is "no trouble." How a teacher beams when he has a boy who "catches on fast," is cooperative and responsible, who doesn't need to be "led out" — in short, hardly needs to be educated! Nature—genetics if you will — has been more farsighted and has furnished us with many people who, although varying from the statistical norms, have added joy and progress to the world of the "average" man. Many mothers will cautiously admit that "Eddie seems to be a little below average," but few have the wisdom and humor to add "but then, most people are."

Essential is the concept of constitution, the concept that differences in shape and size and rate of maturing are genetically determined. We all know families whose sons seem to be slow in growing up, and others whose sons mature early — or families in which the children are fat, while in others they are tall and thin. These are facts beyond the boys' control — are individual differences, one of which is neither better nor worse than the other.

To treat the mature boy in the same manner as the immature, to expose one to the same educational program, the same athletics, the same responsibilities as the other, is to ignore the effect which individual differences have upon achievement — is to neglect the universal need for a little praise, a little approbation, and a little success on the one hand and the benefits of a little censure and adversity on the other.

Along with the obvious differences in physique and level of maturity go differences in social and intellectual interests, control of emotions, quality of judgment. If the stocky, heavy-bearded lad fails to smile and the narrow-shouldered lad in the next seat giggles, it is more natural than wise to approve one and condemn the other; neither was either good or bad — both boys were behaving in a manner natural to their level of maturity, were per-

haps trying in an wakward way *not* to reveal the level of their maturity. It is easy to understand the teacher or parent who complains "I wish he'd grow up," but it is unfortunate that the lad is so frequently criticized for being his own real age. It is the rare boy who doesn't want to grow up — who doesn't want to behave in an adult fashion — but anything as sudden and as screamingly funny as his teacher about to fall flat on his face is too much for the thin veneer of adulthood he has striven so hard to achieve. A rowdy this month may next month view with disgust and alarm (lacking the still more adult perspective and sense of humor) his classmates' uproarious behavior at the movies.

Sam's mother asked if his height was average. It wasn't — and only a small percentage of boys at any age have the "average" height for that age. If one were to study large groups of boys of different nationalities, of differing economic status, of differing nutritional backgrounds, a variety of average figures for height and weight and other measurements would be found. Such factors are not pertinent to this discussion; it is sufficient for this purpose only to consider data applying to American boys who have had the advantage of any of these characteristics in any group, and the fact that all these boys are *normal,* which I wish to emphasize. Those who are quick to see endocrine disorders where there are in reality only constitutional differences may only be fostering in the boy the idea that he is abnormal.

Only one per cent of a group of fourteen-year-old boys fell at the average height, 66.8 inches, for that group, and only 22 per cent of the group fell within one inch of that average. All were normal, healthy boys even though their heights did range from 58.8 to 73.6 inches. The boy who was 73 inches tall was healthy and normal, and so was the boy whose height was 59 inches. Undoubtedly their mothers and fathers worried about their retarded or too rapid growth; and certainly both were far from average. But the important fact is that each was growing in what was for him a normal fashion; that the manner was an unusual rather than a common one might be, for one reason or another, unfortunate. Standardization may be desirable for a chain-store product, but in people as in life, variety lends charm. The average is certainly no "better," no more desirable than the unusual.

Physical maturity can be assessed by the estimate of the skeletal age." X-rays of the hand and wrist show considerable differences; it is upon these changes that an estimation of the "skeletal age" is based. At the age of fourteen it is desirable to

assess physiological or psychological behavior in terms of the lad's state of development rather than in terms of his chronological age. Carefully analyzed data have permitted the establishment of skeletal ages based upon characteristics observable in the hand-wrist X-ray; these skeletal ages closely parallel the level of the secondary sexual characteristics, but there may be wide differences between these boys' chronological and skeletal ages. Estimation of skeletal age is based upon such findings as the extent of closure of the epiphyseal lines — the area in a bone at which growth occurs.

Would it not be well to judge the fourteen-year-old boy in terms of his skeletal age instead of complaining that he has the sense of a twelve-year-old? And to realize that another fourteen-year-old boy with bearded chin might legitimately have the attitudes and interests proper to his skeletal age of sixteen?

Not only in their bones and their exteriors but also in their physiology and their chemistry boys vary. At fourteen some excrete little of those hormanes which influence growth and development. Small wonder that Sam and Bill may have different interests, that Bill may not be the "problem" that Sam is, that Sam has a dreadful case of acne, that Bill's skin is clear as a baby's. What a boon to peace and to understanding would be a home testing set for the assay of Junior's hormone output! It might revolutionize our understanding of his sullen moods, his preoccupation, his size, his indifference to girls, his Petty pictures, his acne. All the admonitions to "scrub your face" and the prohibition of candy — desirable as these may be lest a bad situation be made worse — may only add more friction to home machinery already short on oil.

From month to month, there may be great variations in the amount of hormone an adolescent boy excretes. In some boys the amount steadily increases in adolescence and gradually reaches and maintains an adult level; in others it is as though they went from feast to famine, from oasis to desert, but they too will eventually settle down and fairly regularly excrete relatively average amounts. Adolescents have a right to expect even, tolerant, steady behavior of adults; it must be confessed that *they* do not have to adjust to such variation in their physiology.

3

Rate and state of physical growth are a source of concern to parent and boy, but the slow development of such attributes as a sense of responsibility and an interest in studies worries both parent and teacher, and although their emergence is not as inevi-

table as a beard, the time at which they may become discernible is just as unpredictable. There may be an optimum time for their appearance, but whatever the average may be, it is surely of little significance.

"When is Tom ever going to get interested in school? All he thinks about is the jam sessions at Jimmy Ryan's, girls, and why we don't need the car as much as he does. When do boys usually get serious about school? Won't you please talk to him?"

I had no idea of the average age for a boy to get interested in school, but I found Tom a delightful conversationalist and he vastly improved my own knowledge of swing. During the next two years Tom came in to see me frequently. What he talked about is irrelevant. School was rarely mentioned. Maybe the important thing is that *he* did the talking, that he had a listener who was slow to make suggestions or give advice. Those two years of school may have satisfied those who determine the fine line betwen "pass" and "fail," but little else could be said for them; he was truly, in so far as academic matters were concerned, lying fallow. His parents had long since given up, and had fortunately ceased their exhortations and their half-serious threats — and then what some, who forget they are dealing with youth, call a miracle happened. Tom was in his senior year: he hadn't been near me for a month when one day he burst in, waved a list of school grades under my nose, and let go comments about his ability as a scholar.

We'll never know what did it, but here he was in a moment of supreme joy and ecstasy over what he called some "filthy marks" — this lad who never before would stoop to spend more than a minute even in deprecation of studies. The elation was quickly spent — or sophistication took over — but the academic zeal had persisted, and it is not that of a "grind:" it is that of a boy with real interest in studies, of a boy now attacking them with that great store of energy which he had been saving up all those years. It doesn't always happen, but I'm sure there is no "average" age at which it should appear. Oh yes, Tom did say something about 52nd Street not being as good as it used to be, and the little girl with eyes of blue seemed less glamorous, but his interest in father's car hadn't diminished much. You can't have everything.

There is no evidence that skeletal and emotional and intellectual growth proceed at an equal rate. One can be utterly confused, and frequently disappointed, unless there is a willingness

to appraise an adolescent in terms of his apparent trend rather than his present state or age. It would be easier for everyone if this were not true — if there were definite states one could reasonably expect at various chronological ages. The sad fact is that many adults refuse to look for trends, refuse to estimate the lad's potentialities, insist on comparing him with the average and on judging him as he is. That you can't tell for sure how the cat will jump makes it no less profitable and no less fun and no less important to try to guess: adolescents are not machines — new, shiny, repulsively similar, fresh off the assembly line. They are maddening as a lazy trout, unpredictable and surprising as a land breeze — and brimming with a capacity for change which we adults have lost.

Even after a long dissertation on the turbulence of adolescence and the great differences which may exist between adolescents, I am never surprised to hear a parent say, "That's terribly interesting; but now, about Ted — do you think *he* is normal?" So help me, *every* time!

Maybe the best answer is to finish the stories of Sam and Bill: they are both adults, now normal adults. They just got there at different rates. They both have whiskers, they're both responsible, respected citizens in their college communities. Sam is married, and Bill is serious about a Vassar girl. Their sullenness, their shyness have gone — mother's cookies and father's awful stories are no longer embarrassing. Everything has worked out all right — and in a few years Sam's wife will be worrying about Junior's reticence, and Grandmother will wisely refer to him as her favorite young *man*.

It is easy for the outsider to know and to remember these things: it is unforgivable in him to be smug, to be impatient with the parent whose love and hopes for the youngster make statistics beyond dispute and others' experience hard to accept. Ted might be the exception, and Ted is *their* boy. These questions which have to do with growth and development are not to be answered quickly, to be shut off with a superior air. But the fears which deviation from the average engenders must be allayed; they must not be transmitted to the youngster and added to his own stockpile of anxiety. The thought that he is abnormal, that he is failing to grow properly, must be eliminated. Remember that the sort of person he is, how he feels and behaves, his attitudes and principles, his emotional stability, are of much more importance than any

number assigned to his height or intelligence or state of maturation.

Parents should attempt to hide anxiety and exhibit affection. When a real acceleration or retardation of growth seems to be present, treat it objectively; without hesitation or anxiety or discussion, have it investigated. To the teacher (each of whom expends a year's supply of patience in a day) and to the parent who is losing faith in the capacity of youth to change, I can only suggest that no one, no matter how slow he was in learning to walk, ever *entered* the Yale Bowl on his hands and knees.

* * * * *

Dr. Clair E. Turner, — The World Health Organization is employing Dr. Clair Turner, Assistant to the President of the National Foundation for Infantile Paralysis, for August and September "to conduct a preliminary survey in the field of Health Education and to draft initial plans for the World Health Organization program in this field".

Dr. Turner has received this signal honor because of his distinguished record in Health Education. Among his earlier professional activities, he has served as Chief Health Education Officer of the Institute of Inter-American Affairs, Chairman of the Health Section of the World Federation of Education Association, Chairman of the National Conference for Cooperation in Health Education, and as Chairman of the American Public Health Association Committee on the Educational Qualifications of Health Educators.

* * * * *

Organize School Health Program,—In cooperation with school authorities, physicians of the Waterloo (Iowa) Medical Society, have inaugurated a system of their own for school health. Examinations in high schools were begun last year to insure safety in gymnasium and swimming activities. The physicians have decided that children will be examined in kindergarten and every four years thereafter until they graduate from high school. The doctors are assigned by lot to various schools, and the Board of Education decides on a nominal fee for the medical society after conferring with the doctors. Many physicians work at the schools on Thursday afternoons, their traditional holiday. Dr. Charles A. Waterbury, Jr., is medical chairman of the program. Journal, American Medical Association, May 7, 1949, p. 120.

PROGRAM ANNUAL MEETING

AMERICAN SCHOOL HEALTH ASSOCIATION
NEW YORK — OCT. 24, 1949

Monday, October 24, 1949—
9:30 A.M.

FIRST GENERAL SESSION—

North Ballroom, Hotel New Yorker

Presiding: CYRUS H. MAXWELL, M.D., *President*

Hearing Conservation Program
DONALD R. CAZIARC
California State Health Deparment, Sacramento, California

Vision Program of Philadelphia Schools
RALPH C. LUCIANO, M.D.
Philadelphia Public Schools, Philadelphia, Pennsylvania

Study of School Absences
JOSEPH LINDE, M.D.
City Health Department, New Haven, Connecticut

A Study of 8,000 Children With the Wetzel Grid
ERNEST COUTURE, M.D., *Director*
Division of Child and Maternal Health, Ontario, Canada

A School Medical Advisory Committee Which Works
HENRY W. KAESSLER, M.D.
Bronxville, New York

Monday, October 24, 1949—
2:30 P.M.

SECOND GENERAL SESSION—

North Ballroom, Hotel New Yorker

Presiding: CHARLES KEENE, M.D., *Editor*
Journal of School Health

Panel Discussion: **"The Participation of School Health Personnel in the School Health Education Program"**

Participants:

The Physician—MILDRED E. DOSTER, M.D., Ass't Director
School Health Service, Denver, Colorado

The Health Educator—W. W. PATTY, M.D., Director
Physical Welfare Department, University of Indiana

The Science Instructor—HUBERT EVANS, PH.D.
Teacher's College, Columbia

The Nurse—MARY ELLA CHAYER, R.N., M.A.
Teacher's College, Columbia

Monday, October 24, 1949—
8:30 P.M.

THIRD GENERAL SESSION—

North Ballroom, Hotel New Yorker

Presiding: WM. E. AYLING, M.D., *Director*
School Health, Syracuse, New York

Symposium: **"The Preparation of, and Problems in Securing Adequate School Health Personnel"**

Moderator: FRED HEIN, PH.D.
American Medical Association, Chicago, Ill.

Directors of School Health Depts: CHARLES WILSON, M.D.
Professor of Health Education, Yale University, New Haven, Conn.

Nurses: LULU P. DILWORTH, State Supervisor
School Health and Safety, Trenton, New Jersey

Examining Physicians: DR. PAUL KINNEY, Director
School Health, Pasadena, California

Health Coordinators: HOWARD LUNDY, PH.D.
State Dept. of Health, Seattle, Washington

Tuesday, October 25, 1949—
2:30 P.M.
JOINT SESSION—
Keystone Room, Hotel Statler

Dental Health Section of the American Public Health Association and the American School Health Association

Presiding: DR. PHILIP BLACKERBY and DR. ROBERT DOWNS, *Co-chairmen*

Discussion: "Contributions To a Good School Dental Education Program"

Film: "It's Your Health"

Discussants: MISS MARGARET JEFFREY
MISS EMILY BROWN, *President*
New Jersey School Nurses Association, Elizabeth, New Jersey
SHIRLEY DWYER, *Director,*
Division of Dental Services, State Department of Health, Concord, New Hampshire

Wednesday, October 26, 1949—
9:30 A.M.
JOINT SESSION—
Ballroom, Hotel Statler

Health Officers, Public Health Education, and School Health Sections, and the American School Health Association in Cooperation with the National Committee for Mental Hygiene

Presiding: STANFORD F. FARNSWORTH, M.D., A. HELEN MARTIKAINEN, WARREN H. SOUTHWORTH, DR.P.H., and WILLIAM E. AYLING, M.D.

INCORPORATING MENTAL HYGIENE CONCEPTS INTO PUBLIC HEALTH PROGRAMS

Mental Health Principles in the State and Local Health Program: A Commonwealth Fund Demonstration—H. B. COTTRELL, M.D.

A Health Department Increases the Awareness of its Staff for Mental Hygiene—IVAN C. BERLIEN, M.D.

Nature of Mental Health Programs in Health, Welfare, and Educational Agencies under the National Mental Health Act—HENRY C. SCHUMACHER, M.D.

Wednesday, October 26, 1949—
6:30 P.M.

FOURTH GENERAL SESSION—DINNER MEETING—
Salle Moderne, Hotel Statler

Presiding: CYRUS H. MAXWELL, M.D., *President*

Presentation of the William A. Howe Award to
DR. A. O. DEWEESE, Professor, Health Education, Kent State University, Kent, Ohio
and
DR. CLAIR TURNER, Ass't Director of National Foundation for Infantile Paralysis

Response: DR. A. O. DEWEESE

Response: DR. CLAIR TURNER

Dinner Speaker: COLONEL JAMES P. COONEY
The Schools' Part in Meeting an Attack with the Atom Bomb.

Thursday, October 27, 1949—
9:30 A.M.

JOINT SESSION—
Salle Moderne, Hotel Statler

The Food and Nutrition Section of the American Public Health Association and the American School Health Association

Presiding: DR. MARIETTA EICHELBERG and WALTER WILKINS, M.D., *Co-Chairmen*

"Nutritional Aspects of School Feeding Programs"

"International Aspects of Child Feeding"
MARJORIE L. SCOTT, Nutrition Officer, Nutrition Division, Food and Agriculture Organization of the United Nations, Washington, D. C.

"Preliminary Report of the Canadian Red Cross School Meal Study"
ELIZABETH CHANT ROBERTSON, M.D., Associate Physician Hospital for Sick Children, and Department of Pediatrics, University of Toronto

"School Lunches: Their Nutritive Value and Possible Effect on the Health and Diet of Children"
MILICENT L. HATHAWAY, PH.D., Nutrition Specialist, Food and Nutrition Division, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, United States Department of Agriculture

"The Evaluation of the School Lunch from a Health Standpoint"
CLARENCE A. VELAT, M.D., Division of Chronic Disease, Nutrition Branch, Public Health Service

"The Value of School Lunch in a Community Nutrition Program"
PAULINE BEERY MACK, PH.D., Director, Ellen H. Richards Institute, School of Chemistry and Physics, the Pennsylvania State College

"The Value of School Lunch in a Community Nutrition Program"
ANNA DEPLANTER BOWES, M.S., Chief, Division of Nutrition, Department of Health, Commonwealth of Pennsylvania

Thursday, October 27, 1949—

2:30 P.M.

JOINT SESSION—

Ballroom, Hotel Statler

Maternal and Child Health, Public Health Nursing and School Health Sections, and American School Health Association

Presiding: SARAH S. DEITRICK, M.D., RUTH FREEMAN, R.N., WARREN H. SOUTHWORTH, DR.P.H., and GERTRUDE E. CROMWELL, R.N.

MENTAL HYGIENE IN THE CLASSROOM

A Demonstration of Teaching Procedures Which Lead to Effective Human Relations in the Classroom

The Delaware Human Relations Class Program: H. EDMUND BULLIS

Seventh Grade Class Demonstration, Joan of Arc Junior High School, New York City: M. VIRGINIA MASON

Panel Discussion

Moderator: GEORGE S. STEVENSON, M.D.

Participants: JOSEPH MERSAND, PH.D., EMILY E. O'MALLEY, N. H. DYER, M.D., PAUL STEVENSON, M.D., M. VIRGINIA MASON H. EDMOND BULLIS

Friday, October 28, 1949—

9:30 A.M.

JOINT SESSION—

Keystone Room, Hotel Statler

Dental Health, Maternal and Child Health Medical Care, and Public Health Nursing Sections, and the American School Health Association

Presiding: PHILIP E. BLACKERBY, JR., D.D.S., HAROLD C. STUART, M.D., EDWARD S. ROGERS, M.D., MARGARET L. SHETLAND, R.N., and VLADIMIR K. VOLK, M.D.

AMERICAN ACADEMY OF PEDIATRICS STUDY OF CHILD HEALTH SERVICES

Highlights of the Study and What They Mean for the Improvement of Child Health: JOHN P. HUBBARD, M.D.

Increasing the Teaching of Well Child Care in Pediatric Education: PAUL A. HARPER, M.D.

Joint Planning by the A.A.P. and the A.P.H.A. for the Development of School Health Services: THOMAS E. SHAFFER, M.D.

Public Health Nursing in Relation to Child Health Services: LUCILLE PEROZZI, R.N.

Dental Care for Children: JOHN T. FULTON, D.D.S.

A Demonstration Program for the Decentralization of Pediatric Education Services: GLIDDEN L. BROOKS, M.D.

General Discussion: WARREN R. SISSON, M.D.

Friday, October 28, 1949—

2:30 P.M.

JOINT SESSION—

Grand Ballroom, Hotel New Yorker

Engineering, Epidemiology, Industrial Hygiene, and School Health Sections, and the American School Health Association

Presiding: M. ALLEN POND, JOHN J. PHAIR, M.D., WILLIAM G. FREDRICK, SC.D., WARREN H. SOUTHWORTH, DR.P.H., and DAVID A. VAN DER SLICE, M.D.

AIR SANITATION

The Present Status of Methods for the Control of Airborne Infections: HOLLIS S. INGRAHAM, M.D.

Progress in the Study of the Donora Smog Disaster: JAMES G. TOWNSEND, M.D.

Mechanisms of Spread of Streptococcal Infections in an Infant Nursery: CLAYTON G. LOOSLI, M.D., MARGARET H. D. SMITH, M.D., JEWEL CLINE and LOIS NELSON

The Principles of Aerial Disinfection by Glycol Vapors: WILLIAM LESTER, JR., M.D., O. H. ROBERTSON, M.D., SAUL KAYE and EDWARD W. DUNKLIN

Penetration and Retention of Particulate Matter in Human Lungs in Relation to Particle Size: JACK H. BROWN, PH.D., KENNETH M. COOK, F. GREGG NEY and THEODORE F. HATCH

* * * * *

Right and Left Handedness,—Eustis points out that the physician who is asked whether it is safe and wise to train an apparently left-handed child to use pencil and pen with his right hand can find good authority in the literature for almost any answer he may choose to give. Eustis believes that many apparently left-handed primary grade children may be successfully taught to write with the right hand. When writing begins they should all be so taught, because the use of the right hand fits in better with the left to right direction of writing and also because it conforms to the custom of the majority and hence is easier psychologically. If, however, a child objects strenuously or shows signs of nervous strain, of which stuttering may be one, the attempt should be abandoned at once, and he should be allowed to use his left hand without criticism. Those who are taught to write with the left hand should be shown the proper position of the paper, which is slanted with the top border to the right instead of to the left as is usual. It is often necessary to drill them in the use of this position, since otherwise they are likely to imitate their right-handed neighbors. They should also be allowed to write with a slight backhand slant if they so prefer. Journal, American Medical Association, July 16, 1949, p. 986.

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New York, N. Y.

EDITORIALS

Of the making of books there is no end. This is quite as true in the various phases of school health as in other areas. Seemingly, authors and publishers are trying to make up for the lag of the war years.

There are some general comments concerning these that should be made.

"New editions" in some cases seem "new" only in the sense of being reprintings. These have little value over the old editions. Could it be that the major objective is to get an extension of the copyright date? We know of at least one in which statistical tables of facts that are constantly changing are at least twenty years old.

Some are "new" texts in that they are "new" in so far as the particular authors are concerned. The material, however, is largely a rehash of textbook material that has been appearing for years in older textbooks. Frequently students reporting on recent texts say in effect—"this material on the school health program is practically the same as that in x's text published twenty years ago." Perhaps to the present authors the material is new. We admit that we have to educate every generation, but do not these people—teachers and posing as authorities—read already published texts. If so, almost never do they give credit to the older texts.

On the other hand, sometimes we see a really new text that is so well done professionally and so interestingly written that it—"shines out like a good deed in a naughty world." These are the

texts that—during the reading of so much rehashed material—keep alive one's hopes and encourage to persistence.

Pardon our pessimism, perhaps it is the weather.—*C.H.K.*

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A few years ago* this editor wrote an editorial taking to task those careless—possibly uninformed—speakers and writers who, instead of giving the scientific descriptive title of a disease, label it with the name of some individual who years ago, had something to do with describing or otherwise publicizing the disease. Arteritis obliterans becomes—in the jargon—Buerger's Disease.

Praise be—the light of modernism has broken through the clouds of concealed ideas and ignorance. Dr. Normand L. Hoerr, professor of anatomy at Western Reserve University and managing editor of the New Gould Medical Dictionary, published very recently, thinks that all such terms should be discontinued, and has put the idea into practice. For instance; the New Gould has no entry for Bright's Disease—chronic nephritis—although nephritis is defined, but mentions it in a note about Richard Bright.

The wheels do turn! Congratulations Dr. Hoerr!—*C.H.K.*

*See Journal School Health, Editorial, Vol. IX, No. 7, Sept. 1939, page 209.

ABSTRACTS

School Health Services,*—The National School Health Services Act, passed by the U. S. Senate, provides federal funds under state control to extend the school health program. Annually $35,000,000 would be distributed to the States that have developed plans *approved by the Federal Security Administrator.**

The Journal of the American Medical Association in its Organization Section of July 23, 1949—page 1033—has in essence the following comments concerning this Act.

"The flow of the major fraction of our tax money into the federal treasury and its distribution to the several States in the form of subsidies is a dangerous procedure, and if not properly safeguarded, threatens the security of our form of government." "The evil of this becomes apparent when we see federal subsidy used as a club to compel the adoption by the States of certain procedure."

"Federal control to a greater or lesser degree follows the distribution of federal subsidy". "The States, through their governing bodies are required to accept the provision of the Act as written. The States are then required to submit a plan *acceptable to*

* Italics by Editor, Journal of School Health. C.H.K. (Courts are supposed to consider *all* the evidence. (Is this restriction on their judgment constitutional? *C.H.K.*)

*the Administrator.** If he disapproves—he can block completely the flow of federal funds to that State". (Is this mere coercion or is it bribery?—*C.H.K.*)

While recourse may be had to the courts, "the outcome of the appeal is weighted in favor of the federal administrator since paragraph (b) of Section G states: "The findings of the Federal Administrator unless substantially contrary to the weight of the evidence shall be conclusive".

"The administrator is empowered to invade the State and set up machinery within the State to carry out the purpose of the Act". (Is this constitutional? C.H.K.)

"The assumption that a federal administrator is wiser, more honest, more patriotic and more devoted than any of the administrators of the several States is not in fact true, but is one that is commonly made".

"The setting up of any one pattern in all the States is unnecessary and harmful to true progress since it prevents experimentation and destroys initiative". If 29,000,000 children are to be taught that their health services must stem from the federal government, then in one generation the road to complete federal control of medicine will be open". (Perhaps this is the aim. C.H.K.)

"The only necessary administrative controls should be the proper audit of funds to determine that they have been honestly administered".

Specifically, the bill straight jackets the planning of a State, although the State and localities must put up an amount of money equal to that furnished by the Federal government. State plans should vary with the specific needs in the several States.

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Vaccination Against Smallpox,—Owing largely to a faulty New York State law, which does not—in sizeable cities—require the vaccination against Smallpox of children as a prerequisite to admission to school, there was a considerable threat of a serious Smallpox epidemic, in the Spring of 1947, in the city of New York.

As a result of a campaign urging vaccination against Smallpox, approximately 5,000,000 persons were vaccinated there in April and May 1947. A random sampling of 25,295 vaccinated persons indicated that 74 per cent had successful takes and, therefore, were susceptible to Smallpox.

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* The material quoted was an expression of opposition to the Act, written by Walter B. Martin, M.D., of Norfolk, Va. C.H.K.

Boston Budgets for Athletic Accidents,—A sense of responsibility towards public school children participating in athletics, and thus exposed to accident, has resulted in the introduction of a unique plan by the Boston School Committee.

Legislation for payment, by insurance or otherwise, of reasonable hospital, medical, and surgical expenses for students sustaining injury in any authorized athletic activity was approved by the Governor of Massachusetts in June 1947.

The Boston director of physical education and the business manager immediately began a survey to determine the cost of both athletic competition and physical education injuries in the Boston senior and junior high schools. The figures quoted by insurance companies for coverage were approximately $11,000 for athletic injuries and $16,000 for physical education injuries. After additional study, it was determined that the physical education coverage was entirely out of line and its need problematical.

However, the need for athletic competition coverage was a real one and a survey of injury cases from 1935 to 1947 was begun. Analysis showed that the cost per year, if covered by insurance or otherwise, would have been $7,500. The disparity between the two sets of figures caused the director and business manager to recommend to the school committee adoption of a plan more economical to the city. The decision was made to budget $7,500 annually to cover the cost of athletic injuries.

A summary of the cost of the plan during the school period from 1947 to 1948 was $2,256, which covered injuries in football, hockey, basketball, track and baseball. The school business manager points out the plan is more economical than that advanced by the insurance companies, with a consequent saving to the taxpayer. And it offers better financial and physical protection in athletic activities. School Management, April 1949, p. 22.

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Speech Handicaps,—Although five million persons with speech disorders comprise the largest single group of handicapped persons in America today, scarcely more than 10 per cent of these speech defectives are receiving the attention and training they need, according to Miss Jayne Shover, speech consultant for the National Society for Crippled Children and Adults and Dr. Herbert Koepp-Baker, counselor on speech to the National Society.

There are at least a million stutterers in this country and recent surveys show that one out of every 100 children has a stuttering difficulty.

There is a critical shortage of speech correction workers and a real need for increased scientific research to develop more effective preventive and corrective methods.

"Speech defects are among the most frustrating handicaps when they are misunderstood and neglected." Parents are urged to consult recognized speech clinics and specialists when children show an excessive amount of repetition and hesitation.

To aid in the dissemination of accurate information on speech problems, the National Society in cooperation with the American Speech and Hearing Association recently published a booklet on "Stuttering". Written by Dr. Charles Van Riper, an authority on speech correction, and edited by Dr. Wendell Johnson, the booklet may be obtained from the National Society, 11 S. LaSalle Street, Chicago 3, Illinois, for 35 cents.

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Nurses and Poliomyelitis,—An appropriation of $10,000 from the National Foundation for Infantile Paralysis will assist the American Nurses Association to establish an inventory of registered nurses. During poliomyelitis epidemics it is essential to recruit large numbers of nurses. The usefulness of such inventory will not, however, be limited to poliomyelitis. Data will be obtained concerning education and special preparation and experience in all nursing fields. Journal, American Medical Association, July 9, 1949, p. 904.

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REVIEWS

Fundamentals of Body Mechanics and Conditioning,—Mabel Lee, B.S., LL.D., Miriam M. Wagner, B.A., M.A. pp. 377. W. B. Saunders Company, Philadelphia, 1949. Price $4.50.

This is a text loaded with up-to-date practical advice to teachers in training and might well be used as a basic text for corrective physical education practice. The author's dedication of the book to those masters of precision in gymnastic activities—William Skarstrom, M.D. and Carl Oscar Louis Collin, M.D., gives assurance of the fundamentally sound physical education background of the authors and is refreshing in an era when precision in education seems to be in disrepute.

The material discusses the role of exercise in fitness and in life; the place of body mechanics and conditioning in physical education; conditioning exercises; exercises for special needs, for building cardiorespiratory endurance and certain leading factors

in everyday living. Also it has chapters on teaching techniques, evaluation of the course in body mechanics and conditioning, the organization and conduct of the course in body mechanics and ends with definite course and lesson planning.

This book meets a great need in a field that is much like Mark Twain's idea regarding the weather. There is much talk but little practical effective doing.

The authors are to be congratulated on having produced an authentic, definite and badly needed practical usable text.—*C.H.K.*

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School Health Education,—Delbert Oberteuffer, Harper and Bros., New York, 1949. pp. 404. Price $3.25.

This is a general text in the field of School Health. It is not confined wholly to Health Instruction as its title would indicate, although approximately 140 of its pages are devoted to discussion of—Part II—The Curriculum and Teaching.

The first 35 pages—Part I—discuss briefly the Foundations of the problem—its Responsibilities and Needs and the Basic Problems involved.

The balance of the text is—Part III—devoted to Administration and Activities, dealing almost entirely with the health services in the schools. Appraisal Activities; Control of Communicable Disease; Mental Hygiene, Nutrition; Handicapped Children; Sanitation Standards; and with Personnel, Physical Education and Community relationships.

This text carries a great deal of worthwhile and up-to-date information which is of great value to the workers and administrators in the field of School Health. It is strengthened materially by Selected Readings with the various chapters. An excellent text to have in Teachers College libraries and on one's individual book shelf.—*C.H.K.*

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"Child Health Services and Pediatric Education",—Report of the American Academy of Pediatrics based on the nationwide Survey of the Committee for the Study of Child Health Services, American Academy of Pediatrics, The Commonwealth Fund, New York, 1949, pages 70. Price $3.50.

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Corrective Physical Education,—Josephine L. Rathbone, W. B. Saunders Company, Philadelphia, 1949, pp. 300. Price $3.75.

This is the Fourth Edition of an excellent text on body mechanics and corrective physical education.

Technically accurate, well organized, illustrated by pictures of

classic figures, anatomical sketches and line drawings of suggested corrective exercises, this is a valuable text for student, teacher or practitioner.—*C.H.K.*

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"Outwitting Your Years,"—*Clarence William Lieb, M.D.*, Prentice Hall, Inc., New York, 1949, pp. 278, price $2.75.

This is another addition to the rapidly expanding literature on geriatrics. Its chapters discuss such topics as Mind Sickness and its cure; Sex After Sixty, Why Retire, taking a vigorous thrust at "one of the most vicious concepts, phychologically and physiologically ever generated in the mind of man: the compulsory retirement plan". This the author calls "this legalized form of mass murder".

Written largely in generalities—as it almost has to be in the present state of our knowledge—this is an interesting and valuable book for lay and medical use.—*C.H.K.*

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"Public Health and Hygiene,"—*C. F. Boulduan, M.D.*, and *W. W. Boulduan, M.D.*, W. B. Saunders Co., Fourth Edition, Philadelphia, pp. 423, price $4.25.

The fourth edition of this text derives from the edition of 1929, and was revised in 1936 and 1941. The present one has been brought up to date in its contents, concept and statistics.

Part I presents the history and foundations of public health: Part II discusses the more important communicable diseases, Part III the more important non-communicable diseases, more particularly such chronic diseases as diabetes, heart disease, cancer, endocrine disturbances, hay fever, etc., and mental deviations. Parts IV and V are on the procedures involved in Community Hygiene and in Health Administration.

This is a valuable text to those—such as teachers, nurses, social workers and others who need a brief summarization of the present knowledge and status of the numerous community health factors involved.—*C.H.K.*

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MEETINGS

The American School Health Association and the American 1949. Headquarters of the American School Health Association at Hotel New Yorker.